



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

COPY

C. L. "BUTCH" OTTER – Governor  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0036  
PHONE: (208) 334-6626  
FAX: (208) 364-1888

March 11, 2010

Michael Day  
Independent Living Services Summerwind  
P.O. Box 6395  
Boise, ID 83711

RE: Independent Living Services Summerwind, provider #13G013

Dear Mr. Day:

This is to advise you of the findings of the Medicaid/Licensure survey of Independent Living Services Summerwind, which was conducted on March 11, 2010.

Enclosed is your copy of the Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

*M. Case by mlw*

MICHAEL A. CASE  
Health Facility Surveyor  
Non-Long Term Care

*Nicole Wisenor*

NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

MC/mlw  
Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/11/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/11/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDEPENDENT LIVING SERVICES SUMMERWIND</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>10349 SUMMERWIND DRIVE BOISE, ID 83704</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	<p><b>INITIAL COMMENTS</b></p> <p>Independent Living Services - Summerwind, is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Persons with Mental Retardation,</p> <p>The survey was conducted by: Michael Case, LSW, QMRP Trish O'Hara, RN Jim Troutfetter, QMRP</p>	W 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

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M 000	<p>16.03.11 Initial Comments</p> <p>Independent Living Services - Summerwind, is in compliance with the requirements of Idaho Department of Health and Welfare Rules, Title 03, Chapter 11, "Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF/MR)."</p> <p>The survey was conducted by: Michael Case, LSW, QMRP Trish O'Hara, RN Jim Troutfetter, QMRP</p>	M 000		

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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